



SMA Specialty Medical Lab

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HISTOPATHOLOGY

PATIENT INFORMATION

Last Name	First Name	M.I.		
Street Address	Apt#	City	State	ZIP
Phone	SSN	D.O.B.	M	<input type="checkbox"/>
			F	<input type="checkbox"/>

INSURANCE INFORMATION

Insurance Name	I.D. #	Group#
<input type="checkbox"/> Bill Medicare <input type="checkbox"/> Bill Medicaid <input type="checkbox"/> Bill Patient <input type="checkbox"/> Bill Client		

SPECIMEN INFORMATION

Date Collected: ___/___/___ Time Collected: _____

Fasting: Yes No Fax results to: _____ STAT

ICD10 CODES						
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PLEASE ATTACH COPIES OF FRONT AND BACK OF INSURANCE CARD OR FILL OUT INSURANCE SECTION

*Clinical History and/or Radiologic findings:

Special Requests:

*Operative Procedure:

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Type of Biopsy Excision Shave Punch Curette Other

Biopsy Number	1	2	3	4
Anatomic Site of Biopsy				
Biopsy Number	5	6	7	8
Anatomic Site of Biopsy				

Gross Description:

Physician Signature _____ DATE ___/___/___